

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 1. Short title. This amendatory Act may be referred
5 to as the Health Insurance Consumer Protection Act of 2014.

6 Section 3. Findings and purpose. The General Assembly
7 finds that the federal Patient Protection and Affordable Care
8 Act and the federal regulations implementing that Act give the
9 State and its Department of Insurance primary responsibility
10 for ensuring that all policies of health insurance and health
11 care plans that are offered for sale directly to consumers in
12 the State provide consumers with adequate information about the
13 coverage offered to enable them to meaningfully compare plans
14 and premiums and enroll in the appropriate policy or plan. The
15 purpose of this amendatory Act of the 98th General Assembly is
16 to build on the consumer protections provided in federal law
17 for policies or qualified health plans offered for sale
18 directly to consumers through the Health Insurance Marketplace
19 in Illinois.

20 Section 5. The Illinois Insurance Code is amended by
21 changing Sections 155.36 and 355a as follows:

1 (215 ILCS 5/155.36)

2 Sec. 155.36. Managed Care Reform and Patient Rights Act.
3 Insurance companies that transact the kinds of insurance
4 authorized under Class 1(b) or Class 2(a) of Section 4 of this
5 Code shall comply with Sections 45, 45.1, 45.2, and 85 and the
6 definition of the term "emergency medical condition" in Section
7 10 of the Managed Care Reform and Patient Rights Act.

8 (Source: P.A. 96-857, eff. 7-1-10.)

9 (215 ILCS 5/355a) (from Ch. 73, par. 967a)

10 Sec. 355a. Standardization of terms and coverage.

11 (1) The purpose of this Section shall be (a) to provide
12 reasonable standardization and simplification of terms and
13 coverages of individual accident and health insurance policies
14 to facilitate public understanding and comparisons; (b) to
15 eliminate provisions contained in individual accident and
16 health insurance policies which may be misleading or
17 unreasonably confusing in connection either with the purchase
18 of such coverages or with the settlement of claims; and (c) to
19 provide for reasonable disclosure in the sale of accident and
20 health coverages.

21 (2) Definitions applicable to this Section are as follows:

22 (a) "Policy" means all or any part of the forms
23 constituting the contract between the insurer and the
24 insured, including the policy, certificate, subscriber
25 contract, riders, endorsements, and the application if

1 attached, which are subject to filing with and approval by
2 the Director.

3 (b) "Service corporations" means voluntary health and
4 dental corporations organized and operating respectively
5 under the Voluntary Health Services Plans Act and the
6 Dental Service Plan Act.

7 (c) "Accident and health insurance" means insurance
8 written under Article XX of the Insurance Code, other than
9 credit accident and health insurance, and coverages
10 provided in subscriber contracts issued by service
11 corporations. For purposes of this Section such service
12 corporations shall be deemed to be insurers engaged in the
13 business of insurance.

14 (3) The Director shall issue such rules as he shall deem
15 necessary or desirable to establish specific standards,
16 including standards of full and fair disclosure that set forth
17 the form and content and required disclosure for sale, of
18 individual policies of accident and health insurance, which
19 rules and regulations shall be in addition to and in accordance
20 with the applicable laws of this State, and which may cover but
21 shall not be limited to: (a) terms of renewability; (b) initial
22 and subsequent conditions of eligibility; (c) non-duplication
23 of coverage provisions; (d) coverage of dependents; (e)
24 pre-existing conditions; (f) termination of insurance; (g)
25 probationary periods; (h) limitation, exceptions, and
26 reductions; (i) elimination periods; (j) requirements

1 regarding replacements; (k) recurrent conditions; and (l) the
2 definition of terms including but not limited to the following:
3 hospital, accident, sickness, injury, physician, accidental
4 means, total disability, partial disability, nervous disorder,
5 guaranteed renewable, and non-cancellable.

6 The Director may issue rules that specify prohibited policy
7 provisions not otherwise specifically authorized by statute
8 which in the opinion of the Director are unjust, unfair or
9 unfairly discriminatory to the policyholder, any person
10 insured under the policy, or beneficiary.

11 (4) The Director shall issue such rules as he shall deem
12 necessary or desirable to establish minimum standards for
13 benefits under each category of coverage in individual accident
14 and health policies, other than conversion policies issued
15 pursuant to a contractual conversion privilege under a group
16 policy, including but not limited to the following categories:
17 (a) basic hospital expense coverage; (b) basic
18 medical-surgical expense coverage; (c) hospital confinement
19 indemnity coverage; (d) major medical expense coverage; (e)
20 disability income protection coverage; (f) accident only
21 coverage; and (g) specified disease or specified accident
22 coverage.

23 Nothing in this subsection (4) shall preclude the issuance
24 of any policy which combines two or more of the categories of
25 coverage enumerated in subparagraphs (a) through (f) of this
26 subsection.

1 No policy shall be delivered or issued for delivery in this
2 State which does not meet the prescribed minimum standards for
3 the categories of coverage listed in this subsection unless the
4 Director finds that such policy is necessary to meet specific
5 needs of individuals or groups and such individuals or groups
6 will be adequately informed that such policy does not meet the
7 prescribed minimum standards, and such policy meets the
8 requirement that the benefits provided therein are reasonable
9 in relation to the premium charged. The standards and criteria
10 to be used by the Director in approving such policies shall be
11 included in the rules required under this Section with as much
12 specificity as practicable.

13 The Director shall prescribe by rule the method of
14 identification of policies based upon coverages provided.

15 (5) (a) In order to provide for full and fair disclosure in
16 the sale of individual accident and health insurance policies,
17 no such policy shall be delivered or issued for delivery in
18 this State unless the outline of coverage described in
19 paragraph (b) of this subsection either accompanies the policy,
20 or is delivered to the applicant at the time the application is
21 made, and an acknowledgment signed by the insured, of receipt
22 of delivery of such outline, is provided to the insurer. In the
23 event the policy is issued on a basis other than that applied
24 for, the outline of coverage properly describing the policy
25 must accompany the policy when it is delivered and such outline
26 shall clearly state that the policy differs, and to what

1 extent, from that for which application was originally made.
2 All policies, except single premium nonrenewal policies, shall
3 have a notice prominently printed on the first page of the
4 policy or attached thereto stating in substance, that the
5 policyholder shall have the right to return the policy within
6 10 days of its delivery and to have the premium refunded if
7 after examination of the policy the policyholder is not
8 satisfied for any reason.

9 (b) The Director shall issue such rules as he shall deem
10 necessary or desirable to prescribe the format and content of
11 the outline of coverage required by paragraph (a) of this
12 subsection. "Format" means style, arrangement, and overall
13 appearance, including such items as the size, color, and
14 prominence of type and the arrangement of text and captions.
15 "Content" shall include without limitation thereto, statements
16 relating to the particular policy as to the applicable category
17 of coverage prescribed under subsection 4; principal benefits;
18 exceptions, reductions and limitations; and renewal
19 provisions, including any reservation by the insurer of a right
20 to change premiums. Such outline of coverage shall clearly
21 state that it constitutes a summary of the policy issued or
22 applied for and that the policy should be consulted to
23 determine governing contractual provisions.

24 (c) Without limiting the generality of paragraph (b) of
25 this subsection (5), no qualified health plans shall be offered
26 for sale directly to consumers through the health insurance

1 marketplace operating in the State in accordance with Sections
2 1311 and 1321 of the federal Patient Protection and Affordable
3 Care Act of 2010 (Public Law 111-148), as amended by the
4 federal Health Care and Education Reconciliation Act of 2010
5 (Public Law 111-152), and any amendments thereto, or
6 regulations or guidance issued thereunder (collectively, "the
7 Federal Act"), unless the following information is made
8 available to the consumer at the time he or she is comparing
9 policies and their premiums:

10 (i) With respect to prescription drug benefits, the
11 most recently published formulary where a consumer can view
12 in one location covered prescription drugs; information on
13 tiering and the cost-sharing structure for each tier; and
14 information about how a consumer can obtain specific
15 copayment amounts or coinsurance percentages for a
16 specific qualified health plan before enrolling in that
17 plan. This information shall clearly identify the
18 qualified health plan to which it applies.

19 (ii) The most recently published provider directory
20 where a consumer can view the provider network that applies
21 to each qualified health plan and information about each
22 provider, including location, contact information,
23 specialty, medical group, if any, any institutional
24 affiliation, and whether the provider is accepting new
25 patients. The information shall clearly identify the
26 qualified health plan to which it applies.

1 (d) Each company that offers qualified health plans for
2 sale directly to consumers through the health insurance
3 marketplace operating in the State shall make the information
4 in paragraph (c) of this subsection (5), for each qualified
5 health plan that it offers, available and accessible to the
6 general public on the company's Internet website and through
7 other means for individuals without access to the Internet.

8 (e) The Department shall ensure that State-operated
9 Internet websites, in addition to the Internet website for the
10 health insurance marketplace established in this State in
11 accordance with the Federal Act, prominently provide links to
12 Internet-based materials and tools to help consumers be
13 informed purchasers of health insurance.

14 (f) Nothing in this Section shall be interpreted or
15 implemented in a manner not consistent with the Federal Act.
16 This Section shall apply to all qualified health plans offered
17 for sale directly to consumers through the health insurance
18 marketplace operating in this State for any coverage year
19 beginning on or after January 1, 2015.

20 (6) Prior to the issuance of rules pursuant to this
21 Section, the Director shall afford the public, including the
22 companies affected thereby, reasonable opportunity for
23 comment. Such rulemaking is subject to the provisions of the
24 Illinois Administrative Procedure Act.

25 (7) When a rule has been adopted, pursuant to this Section,
26 all policies of insurance or subscriber contracts which are not

1 in compliance with such rule shall, when so provided in such
2 rule, be deemed to be disapproved as of a date specified in
3 such rule not less than 120 days following its effective date,
4 without any further or additional notice other than the
5 adoption of the rule.

6 (8) When a rule adopted pursuant to this Section so
7 provides, a policy of insurance or subscriber contract which
8 does not comply with the rule shall not less than 120 days from
9 the effective date of such rule, be construed, and the insurer
10 or service corporation shall be liable, as if the policy or
11 contract did comply with the rule.

12 (9) Violation of any rule adopted pursuant to this Section
13 shall be a violation of the insurance law for purposes of
14 Sections 370 and 446 of the Insurance Code.

15 (Source: P.A. 90-177, eff. 7-23-97; 90-372, eff. 7-1-98;
16 90-655, eff. 7-30-98.)

17 Section 10. The Managed Care Reform and Patient Rights Act
18 is amended by changing Section 15 and by adding Sections 45.1
19 and 45.2 as follows:

20 (215 ILCS 134/15)

21 Sec. 15. Provision of information.

22 (a) A health care plan shall provide annually to enrollees
23 and prospective enrollees, upon request, a complete list of
24 participating health care providers in the health care plan's

1 service area and a description of the following terms of
2 coverage:

3 (1) the service area;

4 (2) the covered benefits and services with all
5 exclusions, exceptions, and limitations;

6 (3) the pre-certification and other utilization review
7 procedures and requirements;

8 (4) a description of the process for the selection of a
9 primary care physician, any limitation on access to
10 specialists, and the plan's standing referral policy;

11 (5) the emergency coverage and benefits, including any
12 restrictions on emergency care services;

13 (6) the out-of-area coverage and benefits, if any;

14 (7) the enrollee's financial responsibility for
15 copayments, deductibles, premiums, and any other
16 out-of-pocket expenses;

17 (8) the provisions for continuity of treatment in the
18 event a health care provider's participation terminates
19 during the course of an enrollee's treatment by that
20 provider;

21 (9) the appeals process, forms, and time frames for
22 health care services appeals, complaints, and external
23 independent reviews, administrative complaints, and
24 utilization review complaints, including a phone number to
25 call to receive more information from the health care plan
26 concerning the appeals process; and

1 (10) a statement of all basic health care services and
2 all specific benefits and services mandated to be provided
3 to enrollees by any State law or administrative rule.

4 (a-5) Without limiting the generality of subsection (a) of
5 this Section, no qualified health plans shall be offered for
6 sale directly to consumers through the health insurance
7 marketplace operating in the State in accordance with Sections
8 1311 and 1321 of the federal Patient Protection and Affordable
9 Care Act of 2010 (Public Law 111-148), as amended by the
10 federal Health Care and Education Reconciliation Act of 2010
11 (Public Law 111-152), and any amendments thereto, or
12 regulations or guidance issued thereunder (collectively, "the
13 Federal Act"), unless, in addition to the information required
14 under subsection (a) of this Section, the following information
15 is available to the consumer at the time he or she is comparing
16 health care plans and their premiums:

17 (1) With respect to prescription drug benefits, the
18 most recently published formulary where a consumer can view
19 in one location covered prescription drugs; information on
20 tiering and the cost-sharing structure for each tier; and
21 information about how a consumer can obtain specific
22 copayment amounts or coinsurance percentages for a
23 specific qualified health plan before enrolling in that
24 plan. This information shall clearly identify the
25 qualified health plan to which it applies.

26 (2) The most recently published provider directory

1 where a consumer can view the provider network that applies
2 to each qualified health plan and information about each
3 provider, including location, contact information,
4 specialty, medical group, if any, any institutional
5 affiliation, and whether the provider is accepting new
6 patients. The information shall clearly identify the
7 qualified health plan to which it applies.

8 In the event of an inconsistency between any separate
9 written disclosure statement and the enrollee contract or
10 certificate, the terms of the enrollee contract or certificate
11 shall control.

12 (b) Upon written request, a health care plan shall provide
13 to enrollees a description of the financial relationships
14 between the health care plan and any health care provider and,
15 if requested, the percentage of copayments, deductibles, and
16 total premiums spent on healthcare related expenses and the
17 percentage of copayments, deductibles, and total premiums
18 spent on other expenses, including administrative expenses,
19 except that no health care plan shall be required to disclose
20 specific provider reimbursement.

21 (c) A participating health care provider shall provide all
22 of the following, where applicable, to enrollees upon request:

23 (1) Information related to the health care provider's
24 educational background, experience, training, specialty,
25 and board certification, if applicable.

26 (2) The names of licensed facilities on the provider

1 panel where the health care provider presently has
2 privileges for the treatment, illness, or procedure that is
3 the subject of the request.

4 (3) Information regarding the health care provider's
5 participation in continuing education programs and
6 compliance with any licensure, certification, or
7 registration requirements, if applicable.

8 (d) A health care plan shall provide the information
9 required to be disclosed under this Act upon enrollment and
10 annually thereafter in a legible and understandable format. The
11 Department shall promulgate rules to establish the format
12 based, to the extent practical, on the standards developed for
13 supplemental insurance coverage under Title XVIII of the
14 federal Social Security Act as a guide, so that a person can
15 compare the attributes of the various health care plans.

16 (e) The written disclosure requirements of this Section may
17 be met by disclosure to one enrollee in a household.

18 (f) Each issuer of qualified health plans for sale directly
19 to consumers through the health insurance marketplace
20 operating in the State shall make the information described in
21 subsection (a) of this Section, for each qualified health plan
22 that it offers, available and accessible to the general public
23 on the company's Internet website and through other means for
24 individuals without access to the Internet.

25 (g) The Department shall ensure that State-operated
26 Internet websites, in addition to the Internet website for the

1 health insurance marketplace established in this State in
2 accordance with the Federal Act and its implementing
3 regulations, prominently provide links to Internet-based
4 materials and tools to help consumers be informed purchasers of
5 health care plans.

6 (h) Nothing in this Section shall be interpreted or
7 implemented in a manner not consistent with the Federal Act.
8 This Section shall apply to all qualified health plans offered
9 for sale directly to consumers through the health insurance
10 marketplace operating in this State for any coverage year
11 beginning on or after January 1, 2015.

12 (Source: P.A. 91-617, eff. 1-1-00.)

13 (215 ILCS 134/45.1 new)

14 Sec. 45.1. Medical exceptions procedures required.

15 (a) Every health carrier that offers a qualified health
16 plan, as defined in the federal Patient Protection and
17 Affordable Care Act of 2010 (Public Law 111-148), as amended by
18 the federal Health Care and Education Reconciliation Act of
19 2010 (Public Law 111-152), and any amendments thereto, or
20 regulations or guidance issued under those Acts (collectively,
21 "the Federal Act"), directly to consumers in this State shall
22 establish and maintain a medical exceptions process that allows
23 covered persons or their authorized representatives to request
24 any clinically appropriate prescription drug when (1) the drug
25 is not covered based on the health benefit plan's formulary;

1 (2) the health benefit plan is discontinuing coverage of the
2 drug on the plan's formulary for reasons other than safety or
3 other than because the prescription drug has been withdrawn
4 from the market by the drug's manufacturer; (3) the
5 prescription drug alternatives required to be used in
6 accordance with a step therapy requirement (A) has been
7 ineffective in the treatment of the enrollee's disease or
8 medical condition or, based on both sound clinical evidence and
9 medical and scientific evidence, the known relevant physical or
10 mental characteristics of the enrollee, and the known
11 characteristics of the drug regimen, is likely to be
12 ineffective or adversely affect the drug's effectiveness or
13 patient compliance or (B) has caused or, based on sound medical
14 evidence, is likely to cause an adverse reaction or harm to the
15 enrollee; or (4) the number of doses available under a dose
16 restriction for the prescription drug (A) has been ineffective
17 in the treatment of the enrollee's disease or medical condition
18 or (B) based on both sound clinical evidence and medical and
19 scientific evidence, the known relevant physical and mental
20 characteristics of the enrollee, and known characteristics of
21 the drug regimen, is likely to be ineffective or adversely
22 affect the drug's effective or patient compliance.

23 (b) The health carrier's established medical exceptions
24 procedures must require, at a minimum, the following:

25 (1) Any request for approval of coverage made verbally
26 or in writing (regardless of whether made using a paper or

1 electronic form or some other writing) at any time shall be
2 reviewed by appropriate health care professionals.

3 (2) The health carrier must, within 72 hours after
4 receipt of a request made under subsection (a) of this
5 Section, either approve or deny the request. In the case of
6 a denial, the health carrier shall provide the covered
7 person or the covered person's authorized representative
8 and the covered person's prescribing provider with the
9 reason for the denial, an alternative covered medication,
10 if applicable, and information regarding the procedure for
11 submitting an appeal to the denial.

12 (3) In the case of an expedited coverage determination,
13 the health carrier must either approve or deny the request
14 within 24 hours after receipt of the request. In the case
15 of a denial, the health carrier shall provide the covered
16 person or the covered person's authorized representative
17 and the covered person's prescribing provider with the
18 reason for the denial, an alternative covered medication,
19 if applicable, and information regarding the procedure for
20 submitting an appeal to the denial.

21 (c) Notwithstanding any other provision of this Section,
22 nothing in this Section shall be interpreted or implemented in
23 a manner not consistent with the Federal Act.

24 (215 ILCS 134/45.2 new)

25 Sec. 45.2. Prior authorization form; prescription

1 benefits.

2 (a) Notwithstanding any other provision of law, on and
3 after January 1, 2015, a health insurer that provides
4 prescription drug benefits must, within 72 hours after receipt
5 of a paper or electronic prior authorization form from a
6 prescribing provider or pharmacist, either approve or deny the
7 prior authorization. In the case of a denial, the insurer shall
8 provide the prescriber with the reason for the denial, an
9 alternative covered medication, if applicable, and information
10 regarding the denial.

11 In the case of an expedited coverage determination, the
12 health insurer must either approve or deny the prior
13 authorization within 24 hours after receipt of the paper or
14 electronic prior authorization form. In the case of a denial,
15 the health insurer shall provide the prescriber with the reason
16 for the denial, an alternative covered medication, if
17 applicable, and information regarding the procedure for
18 submitting an appeal to the denial.

19 (b) This Section does not apply to plans for beneficiaries
20 of Medicare or Medicaid.

21 (c) For the purposes of this Section:

22 "Pharmacist" has the same meaning as set forth in the
23 Pharmacy Practice Act.

24 "Prescribing provider" includes a provider authorized to
25 write a prescription, as described in subsection (e) of Section
26 3 of the Pharmacy Practice Act, to treat a medical condition of

1 an insured.

2 Section 99. Effective date. This Act takes effect upon
3 becoming law.